FY 2004
Continuation RFP
for School-Based Health Centers

Texas Department of Health
1100 W. 49th Street
Austin, Texas 78756-3199

Release Date – January 31, 2003
Applications Due by April 15, 2003

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INFORMATION

I. INTRODUCTION

The Texas Department of Health (TDH) School Health Program announces the expected availability of fiscal year (FY) 2004 Maternal and Child Health Block Grant funds to provide second or third year continuation funding for currently funded model school-based health centers (SBHC) that deliver conventional primary and preventive health services and related social services to a school-age population on a school campus. Funds are intended to support school-based health centers that meet the health care needs of students and their families.

Approximately $375,000 is expected to be available to fund approximately five (5) continuing School-Based Health Center projects. The maximum funding available for each of the three (3) third-year projects for the 12-month period is $62,500. The maximum funding available for each of the two (2) second-year projects for the 12-month period is $93,750. The specific dollar amount to be awarded to each applicant will depend upon the documented progress of the project during the prior funding period. Applicants selected for awards must provide matching funds. Funding may vary and is subject to change for each budget period.

This Request for Proposal (RFP) contains the requirements that all applicants must meet to be considered for funding. Failure to conform to these requirements may result in disqualification of the applicant without further consideration. Each applicant is solely responsible for the preparation and submission of an application in accordance with instructions contained in this RFP.

Schedule of Events:

* Post to the Electronic State Business Daily. 01/31/03
* Issuance of RFP 01/31/03
* Deadline for Submission of Applications 04/15/03
* Written Notification to All Applicants 05/15/03
* Estimated Contract Start Date 09/01/03

A. Project and Budget Periods

This continuation application is for the ***second or third year*** budget period within a ***three year*** project period. Continuation contracts will begin on or about **09/01/03**, and will be for a **12**-month budget period.

B. Reservations

Texas Department of Health (TDH) reserves the right to alter, amend, or modify any provisions of this RFP or to withdraw this RFP at any time prior to execution of a contract if it is in the best interest of TDH and the State of Texas. The decision of TDH will be administratively final in this regard.

II. APPLICATION DEADLINE AND SUBMISSION

A. Application Deadline

The application shall be received on or before the following date and time: ***5:00 P.M. C.D.T. on 04/15/02.*** **APPLICATIONS RECEIVED AFTER THE APPLICATION DEADLINE WILL NOT BE CONSIDERED.**

B. Assembly and Submission

1. Assembly

To facilitate review and processing of the applications, each application should meet the following stylistic requirements:

- A Table of Contents
- All pages clearly and consecutively numbered
- original and ***three (3)*** copies unbound
- Typed (computer or typewriter)
- Single-spaced
- 12-point font on 8 ½" x 11" paper with 1" margins
- Blank forms provided in **SECTION VI. BLANK FORMS AND INSTRUCTIONS** shall be used (electronic reproduction of the forms is acceptable)
- Signed in ink by an authorized official (copies need not bear an original signature).

2. Submission

The original application and ***three (3)*** copies shall be submitted to:

Contract Management Section (M-370)
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756-3199

The physical address for overnight and personal deliveries is:

Contract Management Section (M-370)
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756-3199

TDH will not accept applications by facsimile or e-mail.

Applications may be mailed or hand-delivered to the TDH program address above on or before the application deadline.

If an application is hand-delivered to the TDH program address above, applicants should request a receipt at the time of delivery to verify that the application was received by the appropriate program on or before the application due date and time.

If an application is mailed, it is considered as meeting the deadline if it is received on or before the due date and time.

CONTENT AND PREPARATION

III. APPLICATION CONTENT

A. Confidential Information

The applicant shall clearly designate any portion(s) of this application that contains confidential information and state the reasons the information should be designated as such. Marking the entire application as confidential will neither be accepted nor honored. If any information is marked as confidential in the application, TDH will determine whether the requested information may be excepted from disclosure under the Public Information Act, Texas Government Code, Chapter 552. If it constitutes an exception and if a request is made by any other entity for the information marked as confidential, the information may be excepted from disclosure and shall be forwarded to the Texas Attorney General along with a request for a ruling on its confidentiality. Applicants are advised to consult with their legal counsel regarding disclosure issues and to take the appropriate precautions to safeguard trade secrets or any other confidential information. Following the award of any contract, applications to this RFP are subject to release as public information unless any application or specific parts of any application can be shown to be exempt from the Public Information Act, Chapter 552, Texas Government Code.

B. Historically Underutilized Businesses (HUBS)

In accordance with Texas Government Code, Sections 2161.181-182, Health and Human Service (HHS) agencies shall make a good faith effort to assist HUBs in receiving awards issued by the state. The goal of this program is to promote full and equal business opportunity for all businesses in contracting with the state. It is the intent of TDH that all TDH contractors make a good faith effort to subcontract with HUBs during the performance of their contract and to report their HUB subcontract activity to TDH on a quarterly basis. "Subcontract" means a written third party contract between a prime contractor/grantee and another contractor for the performance of all or part of a contract.

Blank HUB forms are included in the RFP. Please read the forms carefully. Completed HUB forms should be returned with the application. All questions concerning HUBs and TDH's HUB program should be directed to the TDH HUB Coordinator at 1-800-243-7487.

The HUB rules (1 Texas Administrative Code 111.11-111.28) may be obtained by contacting the TDH HUB Coordinator or by accessing the Texas Administrative Code on the Internet at http://www.sos.state.tx.us/tac.

C. Table of Contents

THE APPLICATION SHOULD INCLUDE A TABLE OF CONTENTS AND BE ORGANIZED AND ARRANGED IN THE FOLLOWING ORDER:

A. Face Page - Application for Financial Assistance

B. Application Checklist

C. Contact Person Information

D. Administrative Information

E. Performance Measures

F. Work Plan

G. Budget

Other Required Forms and Documentation (Some forms may not be applicable to all applicants; see form instructions for submittal requirements.)

H. Historically Underutilized Businesses (HUBs)

I. Nonprofit Board of Directors and Executive Director Assurances Form

J. Proposed Services Form

IV. BLANK FORMS AND INSTRUCTIONS

Several of the following forms can sum columns and rows of numbers, but you must update them to see the current values.

- To update a single field, click the field or the field results, and then press F9.
- To update all fields in a document, click Select All on the Edit menu, and then press F9.

- To update fields before you print, on the Tools menu, click Options, and then click the Print tab. Under Printing options, select the Update fields check box. Word updates the fields before printing the document.

Caution: Never delete the gray area (text form field) in the box for the total. The Backspace key will delete it. The Delete key will delete it. Try not to touch the field except to update it. The formulas will not work after the text form field (gray area) for the total is deleted. The formulas will not work after an existing total is deleted. This is because the formula needs to put the results in a text form field. If you accidentally delete the text form field for a total, try copying and pasting an unused field for a number from another part of the form, and then update that field.

Texas Department of Health

FORM A: FACE PAGE – Application for Financial Assistance

This form requests basic information about the applicant and project, including the signature of the authorized representative. The face page is the cover page of the application and shall be completed in its entirety.

APPLICANT INFORMATION

1) LEGAL NAME:

2) MAILING Address Information (include mailing address, street, city, county, state and zip code):

Check if address change ☐

3) PAYEE Mailing Address (if different from above):

Check if address change ☐

4) Federal Tax ID No. (9 digit) or **State of Texas Comptroller Vendor ID No.** (14 digit):

5) TYPE OF ENTITY (check all that apply):

☐ City	☐ Nonprofit Organization*	☐ Individual
☐ County	☐ For Profit Organization*	☐ State Controlled Institution of Higher Learning
☐ Other Political Subdivision	☐ HUB Certified	☐ Hospital
☐ State Agency	☐ Community-Based Organization	☐ Private
☐ Indian Tribe	☐ Minority Organization	☐ Other (specify): _____

*****If incorporated, provide 10-digit charter number assigned by Secretary of State:*

6) PROPOSED CONTRACT PERIOD: Start Date: End Date:

7) COUNTIES SERVED BY PROJECT:

8) AMOUNT OF FUNDING REQUESTED:

9) PROJECTED EXPENDITURES

Does applicant's projected state or federal expenditures exceed $300,000 for applicant's current fiscal year (excluding amount requested in line 8 above)? **

Yes ☐ No ☐

***Projected expenditures should include funding for all activities including "pass through" federal funds from all state agencies and non project-related TDH funds.*

10) PROJECT CONTACT PERSON

Name:
Phone:
Fax:
E-mail:

11) FINANCIAL OFFICER

Name:
Phone:
Fax:
E-mail:

The facts affirmed by me in this application are truthful and I warrant that the applicant is in compliance with the assurances and certifications contained in **APPENDIX A: TDH Assurances and Certifications**. I understand that the truthfulness of the facts affirmed herein and the continuing compliance with these requirements are conditions precedent to the award of a contract. This document has been duly authorized by the governing body of the applicant and I (the person signing below) am authorized to represent the applicant.

12) AUTHORIZED REPRESENTATIVE

13) SIGNATURE OF AUTHORIZED REPRESENTATIVE

Name: Phone: Fax: E-mail:	
	14) DATE

FORM A: FACE PAGE Instructions

This form provides basic information about the applicant and the proposed project with the Texas Department of Health (TDH), including the signature of the authorized representative. It is the cover page of the application and required to be completed. Signature affirms that the facts contained in the applicant's response are truthful and that the applicant is in compliance with the assurances and certifications contained in **APPENDIX A: TDH Assurances and Certifications** and acknowledges that continued compliance is a condition for the award of a contract. Please follow the instructions below to complete the face page form and return with the applicant's response.

1) **LEGAL NAME** - Enter the legal name of the applicant.

2) **MAILING ADDRESS INFORMATION** - Enter the applicant's complete street and mailing address, city, county, state, and zip code.

3) **PAYEE MAILING ADDRESS** - Enter the PAYEE's name and mailing address if PAYEE is different from the applicant. The PAYEE is the corporation, entity or vendor who will be receiving payments.

4) **FEDERAL TAX ID/STATE OF TEXAS COMPROLLER VENDOR ID** - Enter the Federal Tax Identification Number (9-digit) or the Vendor Identification Number assigned by the Texas State Comptroller (14-digit).

5) **TYPE OF ENTITY** - The type of entity is defined by the Secretary of State and/or the Texas State Comptroller. Check all appropriate boxes that apply.

HUB is defined as a corporation, sole proprietorship, or joint venture formed for the purpose of making a profit in which at least 51% of all classes of the shares of stock or other equitable securities are owned by one or more persons who have been historically underutilized (economically disadvantaged) because of their identification as members of certain groups: Black American, Hispanic American, Asian Pacific American, Native American, and Women. The HUB must be certified by the General Services Commission or another entity.

MINORITY ORGANIZATION is defined as an organization in which the Board of Directors is made up of 50% racial or ethnic minority members.

If a Non-Profit Corporation or For-Profit Corporation, provide the 10-digit charter number assigned by the Secretary of State.

6) **PROPOSED CONTRACT PERIOD** - Enter contract period for this application. Contract period is defined in the RFP.

7) **COUNTIES SERVED BY PROJECT** - Enter the proposed counties served by the project.

8) **AMOUNT OF FUNDING REQUESTED -** Enter the amount of funding requested from TDH for proposed project activities. This amount must match column (1) row K from FORM I: BUDGET SUMMARY.

9) **PROJECTED EXPENDITURES** - If applicant's projected state or federal expenditures exceed $300,000 for applicant's current fiscal year, applicant shall arrange for a financial and compliance audit (Single Audit).

10) **PROJECT CONTACT PERSON** - Enter the name, phone, fax, and e-mail address of the person responsible for the proposed project.

11) **FINANCIAL OFFICER** - Enter the name, phone, fax, and e-mail address of the person responsible for the financial aspects of the proposed project.

12) **AUTHORIZED REPRESENTATIVE** - Enter the name, phone, fax, and e-mail address of the person authorized to represent the applicant.

13) **SIGNATURE OF AUTHORIZED REPRESENATIVE** - The person authorized to represent the applicant signs in this blank.

14) **DATE** - Enter the date the person authorized to represent the applicant signed this form.

FORM B: APPLICATION CHECKLIST

Legal Name of Applicant: _____

This form is provided to ensure that the application is complete, proper signatures are included, and the required assurances, certifications and attachments have been submitted.

FORM	DESCRIPTION	Included	Not Applicable
A	Face Page completed, and proper signatures and date included	☐	
B	Application Checklist completed and included	☐	
C	Contact Person Information completed and included	☐	
D	Administrative Information completed and included (with supplemental documentation attached if required)	☐	
E	Performance Measures included	☐	
F	Work Plan included	☐	
G	Budget Summary Form completed and included	☐	
G-1–G-7	Budget Category Detail Forms completed and included	☐	
H	TDH Client Services HUB Subcontracting Plan completed and included	☐	☐
I	Nonprofit Board of Directors and Executive Director Assurances form signed and included	☐	☐
J	Proposed Services Form	☐	

FORM C: PROGRAM CONTACT INFORMATION

Legal Name of Applicant: _____

This form provides information about the appropriate program contacts in the applicant's organization in addition to those on FORM A: FACE PAGE. If any of the following information changes during the term of the contract, please notify the ***School Health Program.***

Authorized _____	**Mailing Address (incl. street, city, county, state, &**
Title: _____	_____
Phone _____	_____
Fax: _____	_____
E- _____	_____
School District _____	**Mailing Address (incl. street, city, county, state, &**
Title: _____	_____
Phone _____	_____
Fax: _____	_____
E- _____	_____
Project Director: _____	**Mailing Address (incl. street, city, county, state, &**
Title: _____	_____
Phone _____	_____
Fax: _____	_____
E- _____	_____
SBHC Medical Director: _____	**Mailing Address (incl. street, city, county, state, &**
Title: _____	_____
Phone _____	_____
Fax: _____	_____
E- _____	_____
Business Office _____	**Mailing Address (incl. street, city, county, state, &**
Title: _____	_____
Phone _____	_____
Fax: _____	_____
E- _____	_____

FORM D: ADMINISTRATIVE INFORMATION

This form provides information regarding identification and contract history on the applicant, executive management, project management, governing board members, and/or principal officers. Respond to each request for information ***or provide the required supplemental document behind this form.*** *If responses require multiple pages, identify the supporting pages/documentation with the applicable request.*

Legal Name of Applicant: _____

Identifying Information

1. The applicant shall attach the following information:

If a Governmental Entity

- Names (last, first, middle) and addresses for the officials who are authorized to enter into a contract on behalf of the applicant.

If a Nonprofit or For profit Corporation

- Full names (last, first, middle), addresses, telephone numbers, titles and occupation of members of the Board of Directors or any other principal officers. Indicate what offices are held by members (e.g. chairperson, president, vice-president, treasurer, etc.).
- Full names (last, first, middle), and addresses for each partner, officer, and director as well as the full names and addresses for each person who owns five percent (5%) or more of the stock if applicant is a for profit corporation.

Conflict of Interest and Contract History

The applicant shall disclose any existing or potential conflict of interest relative to the performance of the requirements of this RFP. Examples of potential conflicts may include an existing business or personal relationship between the applicant, its principal, or any affiliate or subcontractor, with TDH, the participating agencies, or any other entity or person involved in any way in any project that is the subject of this RFP. Similarly, any personal or business relationship between the applicant, the principals, or any affiliate or subcontractor, with any employee of TDH, a participating agency, or their respective suppliers, must be disclosed. Any such relationship that might be perceived or represented as a conflict shall be disclosed. Failure to disclose any such relationship may be cause for contract termination or disqualification of the proposal. If, following a review of this information, it is determined by TDH that a conflict of interest exists, the applicant may be disqualified from further consideration for the award of a contract.

1. Does anyone in the applicant organization have an existing or potential conflict of interest relative to the performance of the requirements of this RFP?

☐ **YES** ☐ **NO**

If YES, detail any such relationship(s) that might be perceived or represented as a conflict. (Attach no more than one additional page.)

2. Has any member of applicant's executive management, project management, governing board or principal officers been employed by the State of Texas 24 months prior to the application due date?

☐ **YES** ☐ **NO**

If YES, indicate his/her name, social security number, job title, agency employed by, separation date, and reason for separation.

3. Has applicant had a contract with TDH within the past 24 months?

☐ **YES** ☐ **NO**

If YES, indicate the contract number(s):

Contract Number(s)	

If NO, applicant shall be able to demonstrate fiscal solvency. Submit a copy of the organization's most recently audited balance sheet, statement of income and expenses and accompanying financial footnotes. If audited documentation is not available, provide explanation and submit a complete copy of the most recent Federal Income Tax Return (i.e. Form 990) as filed with the Internal Revenue Service. TDH will evaluate the documents that are submitted and may, at its sole discretion, reject the proposal on the grounds of the applicant's financial capability.

4. Is applicant or any member of applicant's executive management, project management, board members or principal officers:

- delinquent on any state, federal or other debt;
- affiliated with an organization which is delinquent on any state, federal or other debt; or
- in default on an agreed repayment schedule with any funding organization?

☐ **YES** ☐ **NO**

If YES, please explain. (Attach no more than one additional page.)

FORM E: PERFORMANCE MEASURES

In the event a contract is awarded, applicant agrees that performance measures(s) will be used to assess, in part, the applicant's effectiveness in providing the services described. Address all of the requirements (see PERFORMANCE MEASURES Guidelines) associated with the services proposed in this application. ***A maximum of four additional pages may be attached if needed.***

FORM E: PERFORMANCE MEASURE Guidelines

Applicants shall write performance measures for project objectives and proposed target levels of performance for each measure. The proposed measures and levels of performance will be negotiated and agreed upon by applicant and TDH if applicant is selected to negotiate a contract.

Performance measures shall be specific, measurable, time-phased, and feasible. Performance measures quantify program outcomes and outputs, the number of such outputs to be performed, and the efficiency with which they will be performed. Performance measures also define the applicant's obligations in order to meet its contract requirements.

Performance measures are defined as outcome, output, efficiency, and explanatory measures. A well-written measure includes the following components: who will deliver the service(s) and their qualifications (as appropriate); a deliverable (a product or service and how much); a schedule/time frame; and a standard of performance. The following table provides a guide for developing the different types of performance measures:

Type	Measure	Example
Outcome	*measures the actual impact or public benefit of an entity's actions*	*% of clients rehabilitated* *% decline in inappropriate ER usage* *% decline in school absences*
Output or Process	*counts the goods/services provided*	*# of clients served* *# of clinic sessions*
Efficiency	*measures the cost, unit cost, or productivity associated with a given outcome or output*	*average cost per client served* *average time per visit*
Explanatory	*shows the resources used to produce services and display factors that affect entity performance*	*# of clients eligible for services* *# and type of health services presently available* *# of new partnerships developed*

FORM F: WORK PLAN

Provide a description of the SBHC accomplishments achieved during the previous year(s) funded by TDH. Applicants shall describe plan for service delivery to the population in the proposed service area(s) and include timelines for accomplishments.. Describe how FY 2004 activities will build upon the successes of the previous year(s). Describe how the applicant agency is planning to continue the SBHC project after the final year of start-up grant funding. Address the required elements (see WORK PLAN Guidelines) associated with the services proposed in this application. ***A maximum of seven additional pages may be attached if needed.***

FORM F: WORK PLAN Guidelines

Applicant shall describe its plan for service delivery to the population in the proposed service area(s) and include time lines for accomplishments. The work plan shall address the needs and the problems identified in the community assessment for improving health status. The plan shall:

1. Provide a description of the SBHC accomplishments achieved during the previous year(s) funded by TDH.

2. Summarize the proposed services, population to be served, location (counties to be served), etc. Also address the following two questions: a) Will you serve individuals from counties outside your stated service area? b) If you are requesting funds to increase your total project budget (all sources), how will this impact your overall agency program goals

3. Describe delivery systems, workforce (attach organizational chart), policies, support systems (i.e., training, research, technical assistance, information, financial and administrative systems) and other infrastructure available to achieve service delivery and policy-making activities. "What resources do we have to perform the project, who will deliver services and how will they be delivered?"

4. Describe how FY 2004 activities will build upon the successes of the previous year(s).

5. Describe how data is collected and tabulated, who will be responsible for data collection and reporting, and how often data collection activities will occur.

6. Describe coordination with the other health and human services providers in the service area(s) and delineate how duplication of services is to be avoided.

7. Describe ability to provide services to culturally diverse populations (e.g., use of interpreter services, language translation, compliance with ADA requirements, and other means to ensure accessibility for the defined population).

8. Describe internal Quality Assurance/Quality Improvement (QA/QI) process utilized to monitor services, identify staff who utilize them and identify who is responsible for ensuring they are updated. The description shall include the following 1) role of the QA/QI Committee; 2) Medical Director's involvement in the QA/QI activities; 3) activities utilized to identify trends of needed improvement and the frequency of those activities; 4) activities to ensure correction and follow-up to findings identified; 5) utilization and frequency of client satisfaction surveys; 6) system utilized to identify and monitor adverse outcomes (sentinel events); 7) process for identifying outcome measures; and 8) process utilized to develop protocols and Standing Delegation Orders (SDOs).

9. Describe how the applicant agency is planning to continue the SBHC project after the final year of start-up grant funding.

FORM G-1: BUDGET SUMMARY

Legal Name of Applicant: _____

Cost Categories	TDH Funds Requested (1)	Direct Federal Funds (2)	Other State Agency Funds* (3)	Local Funding Sources (4)	Other Funds (5)	Total (6)
A. Personnel	$	$	$	$	$	$
B. Fringe Benefits	$	$	$	$	$	$
C. Travel	$	$	$	$	$	$
D. Equipment	$	$	$	$	$	$
E. Supplies	$	$	$	$	$	$
F. Contractual	$	$	$	$	$	$
G. Construction	N/A	N/A	N/A	N/A	N/A	N/A
H. Other	$	$	$	$	$	$
I. Total Direct Costs	$	$	$	$	$	$
J. Indirect Costs	$	$	$	$	$	$
K. Total (Sum of I and J)	$	$	$	$	$	$
L. Program Income - Projected Earnings	$	$	$	$	$	$

Indirect costs are based on (mark the statement that is accurate):

☐ The applicant's most recently approved indirect cost rate _____ % A copy is attached behind the OTHER Budget Category Detail Form (FORM G7).

☐ The applicant's most recently approved indirect cost rate _____ % which is on file with TDH's Grants Management Division.

☐ Uniform Grant Management Standards. Complete an INDIRECT COST Budget Category Detail Form (FORM G8).

***Letter(s) of good standing that validate the applicant's programmatic, administrative, and financial capability must be placed after this form if applicant receives any funding from other non-TDH state agencies. If the applicant is a state agency or institution of higher education, letter(s) of good standing are not required. DO NOT include non-project related funding in column 3.**

FORM G-1: BUDGET SUMMARY Instructions

An accurate budget plan is essential to achieve the performance measures and work plan set out in the narrative portion of the application. All applicants shall complete the budget summary form. Be sure to refer to the appropriate sections in the RFP for program-specific allowable and unallowable costs.

This form should reflect funding from all sources that support the project described in this attachment. Itemize the amount of support for each funding source and sum rows A through L and columns rows 1-5. See "Detailed Budget Category Forms, Instructions" for definitions of cost categories. For purposes of this form, the column headings have the following meanings:

Column 1: The amount of funds requested from the Texas Department of Health (TDH) for this project.
Column 2: Federal funds awarded directly to applicant.
Column 3: Funds awarded to applicant from other State of Texas governmental agencies.
Column 4: Funds awarded to applicant by local governmental agencies (city, county, local health department, etc.).
Column 5: Funds from other sources not previously addressed in columns 1-4 (third party reimbursements, private foundations, donations, fund-raising).
Column 6: The sum of columns 1-5.

Program Income: Projected Earnings. Applicant must estimate the amount of program income that is expected to be generated during the budget period.

DEFINITION: Program income is the income resulting from fees or charges made by a contractor in connection with activities supported in whole or in part by a federal/state contract. Program income earned as a result of an effort which is jointly funded by TDH and the contractor is to be shared by TDH and the contractor. A program income allocation plan is the means by which TDH's share is determined. The required formula for a plan is as follows:

$$\frac{\text{TDH's Share of Funding}}{\text{TDH's Share of Funding + Contractors Share of Funding}} \times \text{Total Program Income Collected} = \text{TDH's Share of Program Income}$$

Contractor shall disburse program income rebates, refunds, contract settlements, audit recoveries and interest earned on such funds before requesting cash payments including advance payments from TDH.

For more information about program income, refer to the Program Income Article in the General Provisions for TDH Grants Contracts and/or request a copy of TDH's Financial Administrative Procedures Manual from the Grants Management Division or on the Internet at www.tdh.state.tx.us/grants/form_doc.htm.

INSTRUCTIONS:
Projected Earnings. Applicant must enter on the BUDGET SUMMARY form the estimated amount of program income that is expected to be generated during the budget period.

Examples Of Program Income

- *Fees received for personal services performed in connection with and during the period of contract support;*
- *Tuition and fees when the course of instruction is developed, sponsored, and supported by the applicable contract from state or federal sources;*
- *Sale of services such as laboratory tests or computer time;*
- *Payments received from patients or third parties for medical or hospital service, such as Title XIX or Title XX reimbursements, insurance payments, or patient fees. These payments may be made under either a cost reimbursement or a fixed price agreement;*
- *Lease or rental of films or video tapes; and*
- *Rights or royalty payments resulting from patents or copyrights developed or acquired by the contractor.*

Match: Applicants are required to enter the amount of matching funds contributed from the appropriate funding column(s). Costs and third party in-kind contributions counting towards satisfying a cost sharing or matching requirement must be verifiable from the applicant's records. These records must show how the value placed on third party in-kind contributions was derived. To the extent feasible, volunteer services will be supported by the

same methods that the applicant uses to support the allocability of regular personnel costs. Third party in-kind contributions count toward satisfying a cost sharing or matching requirement only where, if the party receiving the contributions were to pay for them, the payments would be allowable costs.

In-Kind: The dollar value of in-kind contributions should be reflected in the appropriate line of row M. In-Kind Match and in the appropriate funding source column heading. The value placed on donated or volunteer services must be reasonable and must be documented to the satisfaction of TDH prior to being accepted as match. Documentation supporting the reasonableness and value of donated or volunteer services must be attached behind the BUDGET SUMMARY form.

Other Match: Enter the dollar amount of funds which will be used to match TDH funds for the proposed activity in row M. Other Match under the column heading which reflects the source of the other match. Match may come from sources such as local funds, other state grants, federal grants, private donations, or private foundations if not otherwise restricted.

SAMPLE

FORM G-1: BUDGET SUMMARY Sample

Legal Name of Applicant: Apple County Health Department

Cost Categories	TDH Funds Requested (1)	Direct Federal Funds (2)	Other State Agency Funds* (3)	Local Funding Sources (4)	Other Funds (5)	Total (6)
A. Personnel	$ 27,900	$ 30,900	$ 5,000	$ 0	$ 0	$ 63,800
B. Fringe Benefits	$ 4,032	$ 5,030	$ 1,000	$ 0	$ 0	$ 10,062
C. Travel	$ 1,373	$ 2,070	$ 5,00	$ 0	$ 0	$ 3,448
D. Equipment	$ 2,060	$ 3,050	$ 2,050	$ 1,500	$ 0	$ 8,660
E. Supplies	$ 45,000	$ 46,000	$ 20,000	$ 5,500	$ 0	$ 116,500
F. Contractual	$ 41,208	$ 42,010	$ 15,000	$ 0	$ 0	$ 98,218
G. Construction	N/A	N/A	N/A	N/A	N/A	N/A
H. Other	$ 23,000	$ 1,000	$ 500	$ 0	$ 0	$ 24,500
I. Total Direct Costs	$ 144,573	$ 130,060	$ 44,050	$ 7,000	$ 0	$ 325,683
J. Indirect Costs	$ 2,025	$ 900	$ 650	$ 0	$ 0	$ 3,575
K. Total (Sum of I and J)	$ 146,598	$ 130,960	$ 44,700	$ 7,000	$ 0	$ 329,258
L. Program Income --Projected Earnings	$ 13,200	$ 12,000	$ 4,200	$ 600	$ 0	$ 30,000

Indirect costs are based on (mark the statement that is accurate):

[ ] The applicant's most recently approved indirect cost rate _____ % A copy is attached behind the OTHER Budget Category Detail Form (FORM G7).

[ ] The applicant's most recently approved indirect cost rate _____ % which is on file with TDH's Grants Management Division.

[X] Uniform Grant Management Standards. Complete an INDIRECT COST Budget Category Detail Form (FORM G8).

***Letter(s) of good standing that validate the applicant's programmatic, administrative, and financial capability must be placed after this form if applicant receives any funding from other non-TDH state agencies. If the applicant is a state agency or institution of higher education, letter(s) of good standing are not required. DO NOT include non-project related funding in column 3.**

DETAILED BUDGET CATEGORY FORMS

General Information

Requirements for Categorical Budgets

The application shall include a detailed breakdown of budget cost categories and a narrative justification. Details of each cost category shall be expressed using the budget category detail forms (I1-I7), which follow. Definitions of the cost categories and instructions and examples of how to itemize the contents of each cost category are included after the budget category detail forms. Computer generated facsimiles may be substituted for any of the forms; however, the exact wording and format must be maintained.

General Information

Additional information on basic accounting and financial management systems requirements is available in TDH's Financial Administrative Procedures Manual. Copies of the manual are available from the Grants Management Division or on the Internet at www.tdh.state.tx.us/grants/forms_and_documents.htm.

Only those costs allowable under UGMS and any revisions thereto plus any applicable federal cost principles are eligible for reimbursement under this contract. Applicable cost principles, audit requirements, and administrative requirements are as follows:

Applicable Cost Principles	Audit Requirements	Administrative Requirements
OMB Circular A-87, State & Local Governments	OMB Circular A-133	UGMS
OMB Circular A-21, Educational Institutions	OMB Circular A-133	OMB Circular A-110
OMB Circular A-122, Non Profit Organizations	OMB Circular A-133 and UGMS	UGMS
48 CFR Part 31, For Profit Organization and other than a hospital and an organization named in OMB Circular A-122 as not subject to that circular	Program audit conducted by an independent certified public accountant must be in accordance with Governmental Auditing Standards.	

A. Allowable and Unallowable Costs

Below is a brief listing of allowable and unallowable costs as prescribed by federal cost principles or TDH policy. Applicable federal cost principles provide additional information and guidance on allowable and unallowable costs.

An **allowable cost**, in accordance with federal cost principles, meets the following criteria:

1. It is necessary and reasonable for proper and efficient administration of the funded program;
2. It can be allocated to the funded program and is not a general expense needed to carry out the contractor's general responsibilities;
3. It is authorized or is not prohibited under applicable laws or regulations;
4. It conforms to applicable limitations or exclusions;
5. It is consistent with applicable policies and procedures;
6. It is treated consistently through the application of generally accepted accounting principles appropriate to the circumstances;
7. It is not allocated or included as a cost of any other program; and
8. It is the net sum of all applicable credits.

Unallowable costs, i.e., costs that may not be paid with TDH funds include, but are not limited to:

1. Advertising and public relations costs other than those specifically allowed by terms of the contract attachment or those incurred for the purpose of personnel recruitment, solicitation of bids and disposal of surplus materials;
2. Bad debts;
3. Construction is not allowed without the prior written approval of TDH;
4. Contingency reserve funds;
5. Contributions and donations;
6. Entertainment costs including amusement/social activities and their related costs (meals, beverages, lodgings, rentals, transportation, and gratuities) are not allowed unless the costs are directly related to the program's purpose and TDH has reviewed and issued prior written approval of the work plan components that relate to entertainment costs;
7. Fines, penalties, late payment fees, bank overdraft charges;
8. Fundraising;
9. Interest (unless specifically authorized by applicable cost principles or authorized by federal or state legislation);
10. Lobbying;
11. Underrecovery of costs under Federal Agreements. Any excess costs over the Federal contribution under one award agreement are unallowable under other award agreements.

B. Direct Costs

Direct costs are those that can be specifically identified with a particular award, project, service, scope of work or other direct objective of an organization. These costs may be charged directly to the TDH contract attachment (if applicant is awarded a contract). These costs may also be charged to cost objectives used to accumulate all costs pending distribution to specific contracts and other purposes. Direct cost categories include: personnel, fringe benefits, travel, equipment, supplies, contractual, and other.

C. Indirect Costs

Indirect costs are those that have been incurred for common or joint objectives and cannot be readily identified with a particular final cost objective. The amount of indirect costs that may be charged to any resulting TDH contract attachment is determined by negotiation and will be defined in the contract budget attachment.

D. Audit Requirements

If required by OMB Circular A-133 and/or UGMS, applicant or applicant's authorized contracting entity shall arrange for a financial and compliance audit (Single Audit). Applicant may include in the budget request an amount for TDH's proportionate share of costs. The audit must be conducted by an independent CPA and must be in accordance with applicable OMB Circulars, Government Auditing Standards, and UGMS. Audit services shall be procured in compliance with state procurement procedures, as well as the provisions of UGMS.

FORM G-2: PERSONNEL Budget Category Detail Form

Legal Name of Applicant: _____

Functional Title + Code E=Existing or P=Proposed	% Time	Certification/ License Required	Total Annual Salary	Salary Requested for Project	Vacant Y/N	Justification

FRINGE BENEFITS: Itemize the elements of fringe benefits in this space. Attach an additional sheet of paper if more space is required.

Salary Total	$
Fringe Benefit Rate %	%
FRINGE BENEFITS TOTAL	$

FORM G-2: PERSONNEL (MATCH) Budget Category Detail Form

Legal Name of Applicant: _____

Functional Title + Code E=Existing or P=Proposed	% Time	Certification/ License Required	Total Annual Salary	Salary Requested for Project	Vacant Y/N	Justification

FRINGE BENEFITS: Itemize the elements of fringe benefits in this space. Attach an additional sheet of paper if more space is required.	**Salary Total**	$
	Fringe Benefit Rate %	%
	FRINGE BENEFITS TOTAL	$

SAMPLE

FORM G-2: PERSONNEL Budget Category Detail Form Sample

Legal Name of Applicant: Apple County Health Department

Functional Title + Code E=Existing or P=Proposed	% Time	Certification/ License Required	Total Annual Salary	Salary Requested for Project	Vacant Y/N	Justification
Financial Officer (E)	5%		$42,000	$2,100	N	Provides financial accountability of program
Administrative/Personnel (P)	5%		$36,000	$1,800	Y	Provides personnel services and training
Outreach Counselor (E)	100%		$24,000	$24,000	N	Provides outreach/case management services

FRINGE BENEFITS: Itemize the elements of fringe benefits in this space. Attach an additional sheet of paper if more space is required. FICA 7.65% Worker's Comp 2.05% Retirement Plan 1.63% Health Insurance 3.12%	Salary Total	$27,900
	Fringe Benefit Rate 14.45 % FRINGE BENEFITS TOTAL	$4,032

PERSONNEL

DEFINITION: Actual salaries and wages for all staff positions in the proposed project that will provide direct care and administrative services (including clerical) to the project.

INSTRUCTIONS: Enter the following information for each position on the PERSONNEL Budget Category Detail Form: functional title, whether the position is existing or proposed, % of time dedicated to the project, any certification or license an individual must possess to be qualified for the position, the total annual salary, the amount of TDH funds requested for this position's salary (% of time dedicated to the project multiplied by the annual salary), whether the position is vacant or filled, and the justification for the position. Justification may include a brief description of the position's primary responsibilities and an explanation for the % of time dedicated to the project, why the position classification is appropriate (including license/certification requirements), and an explanation of reasonableness of the annual salary.

FRINGE BENEFITS

DEFINITION: Fringe benefits paid by the applicant on behalf of its employees. This includes employer contributions for social security, retirement, health and accident insurance, and workers' compensation insurance. Fringe benefits requested should represent actual benefits paid for employees.

INSTRUCTIONS: Itemize the elements of fringe benefits and indicate the % rate on the PERSONNEL Budget Category Detail Form.

FORM G-3: TRAVEL Budget Category Detail Form

Legal Name of Applicant: _____

Local Travel Costs (mileage plus per diem)

Mileage Reimbursement Rate	Estimated Number of Miles	Estimated Mileage Cost (a)	Estimated Per Diem Costs (b)	Estimated Total Local Travel Costs (a) + (b)	Justification (include who or what position will be traveling, area or locations to cover, and why local travel is necessary to accomplish the project)
$		$	$	$	

Conference/Workshop Costs

Name and/or Description of Conference/Workshop	Location (City)	No. of Applicant Employees Attending (for whom TDH funds are requested)	Estimated Travel Cost (# of miles x reimbursement rate; estimated airfare, etc.)		Estimated Per Diem Cost	Estimated Related Travel Costs (taxi, etc.)	Estimated Total Conference/ Workshop Cost	Justification
TOTAL for Conf/Workshop TRAVEL:			$		$	$	$	

Local TRAVEL Costs: $	**Conf/Workshop TRAVEL Costs:** $	**Total TRAVEL Costs:** $

NOTE: All contracts with the Texas Department of Health require that a written travel policy be maintained by the contracting entity. Attach a copy of the travel policy as an appendix to the proposal. If a written travel policy is not in place, TDH's travel policy will be used.

FORM G-3: TRAVEL (MATCH) Budget Category Detail Form

Legal Name of Applicant: _____

Local Travel Costs (mileage plus per diem)

Mileage Reimbursement Rate	Estimated Number of Miles	Estimated Mileage Cost (a)	Estimated Per Diem Costs (b)	Estimated Total Local Travel Costs (a) + (b)	Justification (include who or what position will be traveling, area or locations to cover, and why local travel is necessary to accomplish the project)
$		$	$	$	

Conference/Workshop Costs

Name and/or Description of Conference/Workshop	Location (City)	No. of Applicant Employees Attending (for whom TDH funds are requested)	Estimated Travel Cost (# of miles x reimbursement rate; estimated airfare, etc.)		Estimated Per Diem Cost	Estimated Related Travel Costs (taxi, etc.)	Estimated Total Conference/ Workshop Cost	Justification
TOTAL for Conf/Workshop TRAVEL:			$		$	$	$	

Local TRAVEL Costs: $	**Conf/Workshop TRAVEL Costs:** $	**Total TRAVEL Costs:** $

NOTE: All contracts with the Texas Department of Health require that a written travel policy be maintained by the contracting entity. Attach a copy of the travel policy as an appendix to the proposal. If a written travel policy is not in place, TDH's travel policy will be used.

SAMPLE

FORM G-3: TRAVEL Budget Category Detail Form Sample

Legal Name of Applicant: Apple County Health Department

Local Travel Costs (mileage plus per diem)

Mileage Reimbursement Rate	Estimated Number of Miles	Estimated Mileage Cost (a)	Estimated Per Diem Costs (b)	Estimated Total Local Travel Costs (a) + (b)	Justification (include who or what position will be traveling, area or locations to cover, and why local travel is necessary to accomplish the project)
$ .31	1,068	$ 331	$ 144	$ 475	Executive Director – Travel to all site locations in the nineteen county area for review, monitor, evaluate, and oversee clinic operations.

Conference/Workshop Costs

Name and/or Description of Conference/Workshop	Location (City)	No. of Applicant Employees Attending (for whom TDH	Estimated Travel Cost (# of miles x reimbursement rate; estimated airfare, etc.)		Estimated Per Diem Cost	Estimated Related Travel Costs (taxi, etc.)	Estimated Total Conference/ Workshop Cost	Justification
Family Planning Advisory Committee Meetings (4)	Austin	1	1,735 miles x $0.31/mile =	$538	$360	$0	$898	Clinic Services Director to attend Family Planning Committee meetings (4)
TOTAL for Conf/Workshop TRAVEL:				$538	$360	$0	$898	

Local TRAVEL Costs:	$475	Conf/Workshop TRAVEL Costs	$898	Total TRAVEL Costs:	$1,373

NOTE: All contracts with the Texas Department of Health require that a written travel policy be maintained by the contracting entity. Attach a copy of the travel policy as an appendix to the proposal. If a written travel policy is not in place, TDH's travel policy will be used.

TRAVEL

DEFINITION: The costs of transportation, lodging, meals and related expenses incurred by the applicant's staff while traveling to perform duties required by the proposed project are classified as travel. This includes personal auto mileage for travel by employees. Costs related to client transportation, registration fees, and travel associated with contractual staff should be classified as "Other", not "Travel."

INSTRUCTIONS: The TRAVEL Budget Category Detail Form requires information on local travel costs (travel and per diem) and information on conferences/workshops for which TDH funding is being requested. For local travel, enter the reimbursement rate for automobile mileage and the estimated number of miles to be traveled for the budget period. To calculate the total estimated local travel costs, multiply the local reimbursement rate per mile by the total estimated number of automobile miles. Enter the estimated per diem costs which may be associated with local travel and show the basis for cost (15 partial days x $7 per partial day = $105). The justification should include who or what position classification(s) will be traveling and why local travel is necessary to accomplish the project. For conferences/workshops, the following must be included for all attending for whom

TDH funds are being requested: the name and/or description of the conference/workshop, the location (city), the number of persons attending, estimated travel, per diem, other related travel costs (excluding registration fees) and total costs for all attending. The justification should include how attendance at the conference/workshop will directly benefit the project and why it is necessary to accomplish the project.

FORM G-4: EQUIPMENT Budget Category Detail Form

Legal Name of Applicant: _____

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order. See attached sample for equipment definition and detailed instructions to complete this form.

DESCRIPTION OF ITEM (e.g., $1,000 or Exception)	COST PER UNIT / # OF UNITS	UNIT TOTAL	PURPOSE & JUSTIFICATION
TOTAL Amount Requested for EQUIPMENT:		$	

FORM G-4: EQUIPMENT (MATCH) Budget Category Detail Form

Legal Name of Applicant: _____

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order. See attached sample for equipment definition and detailed instructions to complete this form.

DESCRIPTION OF ITEM (e.g., $1,000 or Exception)	COST PER UNIT / # OF UNITS	UNIT TOTAL	PURPOSE & JUSTIFICATION
TOTAL Amount Requested for EQUIPMENT:		$	

SAMPLE

FORM G-4: EQUIPMENT Budget Category Detail Form Sample

Legal Name of Applicant: Apple County Health Department

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order.

DESCRIPTION OF ITEM (e.g., $1,000 or Exception)	COST PER UNIT / # OF UNITS	UNIT TOTAL	PURPOSE & JUSTIFICATION
Laptop Computer Dell Inspiron 8000, Intel Pentium III Processor at 850 MHZ, .32 KB Internal Cache (L1), 100 MHZ (Pentium III) external BUS, Frequency and 66 MHZ (Celeron) external BUS frequency Intel 815e AGP, Set Chipset with 4X AFP memory	$2,060 / 1	$2,060	Administrative processing and billing for Community Power Point presentation on the value of Family Planning
TOTAL Amount Requested for EQUIPMENT:		$ 2,060	

EQUIPMENT

DEFINITION: Equipment is defined by TDH as non-expendable personal property with a unit cost of more than $1,000.00 and a useful life of more than one year, with the following exceptions: fax machines, stereo systems, cameras, video recorders/players, microcomputers, printers, software, medical and laboratory equipment. Medical and laboratory equipment in this category is defined as microscopes, oscilloscopes, centrifuges, balances, and incubators. Medical and laboratory equipment not included in these five categories are not considered a capital asset unless the unit value is over $1,000.00. The exception items listed will still be inventoried if their unit cost plus any items used with or attached to the unit is $500.00 or greater. For items with component parts (i.e., computers), the aggregate cost must be considered when applying the $500/$1,000 threshold.

INSTRUCTIONS: Enter the following information on the EQUIPMENT Budget Category Detail Form for each type of equipment item: description of each item, the cost per unit, the number of units to be purchased, the total amount for the line item (multiply the cost per unit by the number of units), state the purpose for the item(s) and why the equipment is necessary and how the applicant determined or will determine that the cost is reasonable. Attach a complete specification or a copy of the purchase order.

EXAMPLES OF EQUIPMENT DESCRIPTIONS

Remember: Equipment is priced **per unit** including freight. If you intend to purchase 10 modems @ $95 each, this would be considered a supply item not an equipment item.

INCORRECT EXAMPLES	CORRECT EXAMPLES
Computer-850 Mhz Pentium	Laptop Computer Dell Inspiron 8000, Intel Pentium III Processor at 850 MHz, .32 KB Internal Cache (L1), 100 MHZ (Pentium III)
1 @ $2,150	external BUS, Frequency and 66 MHZ (Celeron) external BUS frequency Intel 815e AGP, Set Chipset with 4X AFP memory.
(insufficient description/specification)	1 @ $2,150
1 @ $250 Laser Jet Printer	24" Zenith Portable TV/VCR Combination;

(This item would be moved to supplies as it is less than $500.00).	Model #Z12345 1 @ $750

FORM G-5: SUPPLIES Budget Category Detail Form

Legal Name of Applicant: _____

Itemize, describe and justify the supply items listed below. Costs may be categorized by each general type (e.g., office, computer, medical, educational, janitorial, etc.). See attached sample for definition of supplies and detailed instructions to complete this form.

DESCRIPTION OF ITEM (e.g., $1,000 excluding equipment exceptions)	COST PER UNIT / # OF UNITS	UNIT TOTAL	PURPOSE & JUSTIFICATION
TOTAL Amount Requested for SUPPLIES:		$	

FORM G-5: SUPPLIES (MATCH) Budget Category Detail Form

Legal Name of Applicant: _____

Itemize, describe and justify the supply items listed below. Costs may be categorized by each general type (e.g., office, computer, medical, educational, janitorial, etc.). See attached sample for definition of supplies and detailed instructions to complete this form.

DESCRIPTION OF ITEM (e.g., $1,000 excluding equipment exceptions)	COST PER UNIT / # OF UNITS	UNIT TOTAL	PURPOSE & JUSTIFICATION
TOTAL Amount Requested for SUPPLIES:		$	

SAMPLE

FORM G-5: SUPPLIES Budget Category Detail Form Sample

Legal Name of Applicant: Apple County Health Department

Itemize, describe and justify the supply items listed below. Costs may be categorized by each general type (e.g., office, computer, medical, educational, janitorial, etc.).

DESCRIPTION OF ITEM (e.g., $1,000 excluding equipment exceptions)	COST PER UNIT / # OF UNITS	UNIT TOTAL	PURPOSE & JUSTIFICATION
Office supplies	$750 / month	$9,000	Supports Family Planning clinic services
Pharmaceuticals	$3,000 / month	$36,000	Medications to serve patients
TOTAL Amount Requested for SUPPLIES:		$ 45,000	

SUPPLIES

DEFINITION: Costs for materials and supplies necessary to carry out the program. This includes medical supplies, drugs, janitorial supplies, office supplies, patient educational supplies, software less than $500, plus any equipment or furniture with a purchase price including freight not to exceed $1,000 per item, except those listed in the "equipment" category.

INSTRUCTIONS: Enter the following information in the SUPPLIES Budget Category Detail Form for each general category or type of supplies: description of the items, the cost per unit, the number of units to be purchased, the total amount for the line item (multiply the cost per unit by the number of units), and state the purpose for the item(s), why the supplies are necessary and how the applicant determined or will determine that the cost is reasonable.

FORM G-6: CONTRACTUAL Budget Category Detail Form

Legal Name of Applicant: _____

List contracts for services related to the scope of work that are to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors as "To Be Named." Justification for any contract that delegates a substantial portion of the scope of the project, i.e., $25,000 or 25% of the applicant's funding request, whichever is greater, must be attached behind this form.

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	METHOD OF REIMBURSEMENT (Unit Cost or Cost Reimbursement)	# of Hours or Units of Service	UNIT COST RATE (If Applicable)	CONTRACTOR TOTAL	JUSTIFICATION

TOTAL Amount Requested for CONTRACTUAL: $

FORM G-6: CONTRACTUAL (MATCH) Budget Category Detail Form

Legal Name of Applicant: _____

List contracts for services related to the scope of work that are to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors as "To Be Named." Justification for any contract that delegates a substantial portion of the scope of the project, i.e., $25,000 or 25% of the applicant's funding request, whichever is greater, must be attached behind this form.

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	METHOD OF REIMBURSEMENT (Unit Cost or Cost Reimbursement)	# of Hours or Units of Service	UNIT COST RATE (If Applicable)	CONTRACTOR TOTAL	JUSTIFICATION

TOTAL Amount Requested for CONTRACTUAL: $

SAMPLE

FORM G-6: CONTRACTUAL Budget Category Detail Form Sample

Legal Name of Applicant: Apple County Health Department

List contracts for services related to the scope of work that are to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors as "To Be Named." Justification for any contract that delegates a substantial portion of the scope of the project, i.e., $25,000 or 25% of the applicant's funding request, whichever is greater, must be attached behind this form.

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	METHOD OF REIMBURSEMENT (Unit Cost or Cost Reimbursement)	# of Hours or Units of Service	UNIT COST RATE (If Applicable)	CONTRACTOR TOTAL	JUSTIFICATION
Dr. Bob Health, D.O.	Oversees medical services	Unit Cost	month	$300	$3,600	Medical Director required by TDH
Dr. Peter Paul, D.O.	Provides health history & physicals	Unit Cost	130 hours/ month	$3,034	$36,408	Contract physician at clinics performing medical exams
Dr. Billy Bob, D.O.	Provide professional guidance	Cost Reimburse	N/A	N/A	$1,200	Medical Consultant
				TOTAL Amount Requested for CONTRACTUAL:	$ 41,208	

CONTRACTUAL

DEFINITION: Activities identified in the scope of work that are delegated by the applicant to a third party; the cost of providing these activities is recorded in this category. Travel costs incurred by a third party while performing these activities should be included in this category. Contracts for administrative services are not included in this category; they are properly classified in the Other category.
If the applicant enters into grant contracts with subrecipients or procurement contracts with vendors, the documents will be in writing and will comply with the requirements specified in the Contracts with Subrecipients and Contracts for Procurement articles in the General Provisions for Texas Department of Health Grant Contracts available online at *www.tdh.state.tx.us/grants/form_doc.htm* or by calling Grants Management Division at 512-458-7470.

If an applicant plans to enter into a contract which delegates a substantial portion of the scope of the project, i.e., $25,000 or 25% of the applicant's funding request whichever is greater, the applicant must submit justification to TDH and receive prior written approval from TDH before entering into the contract.

INSTRUCTIONS: The CONTRACTUAL Budget Category Detail Form requires names of the individuals or organizations performing the services, a description of the services being contracted, the number of hours or units of service to be purchased, the method of reimbursement (cost reimbursement or unit cost), unit cost if applicable and total amount of each subcontract. Justification should include why applicant intends to contract for the service, why the service is necessary to perform the scope of work and how the applicant will ensure that the cost of the service is reasonable.

Justification for contracts that delegate a substantial portion of the scope of the project, i.e., $25,000 or 25% of the applicant's funding request whichever is greater, must be attached behind the CONTRACTUAL Budget Category Detail Form.

FORM G-7: OTHER Budget Category Detail Form

Legal Name of Applicant: _____

DESCRIPTION	(# of units x unit cost if applicable)	COST	PURPOSE & JUSTIFICATION

TOTAL Amount Requested for OTHER:	$

FORM G-7: OTHER (MATCH) Budget Category Detail Form

Legal Name of Applicant: _____

DESCRIPTION	(# of units x unit cost if applicable)	COST	PURPOSE & JUSTIFICATION

TOTAL Amount Requested for OTHER:	$

SAMPLE

FORM G-7: OTHER Budget Category Detail Form Sample

Legal Name of Applicant: Apple County Health Department

DESCRIPTION	# of units x unit cost if applicable	COST	PURPOSE & JUSTIFICATION
Telephone (23 lines)	12 months x $833.34 =	$10,000	Telephone service
Printing	12 months x $666.67 =	$8,000	Documents, forms, letters, and literature
Single Audit	1 x $5,000 =	$5,000	Single Audit (TDH requirement)
TOTAL Amount Requested for OTHER:	$	23,000	

OTHER

DEFINITION: All other allowable direct costs not listed in any of the above categories are to be included in this category. Some of the major costs that should be budgeted in this category are:

* contracts for administrative services;
* space and equipment rental;
* utilities and telephone expenses;
* data processing services;
* printing and reproduction expenses;
* postage and shipping;
* contract clerical or other personnel services;
* janitorial services;
* exterminating services;
* security services;
* insurance and bonds;
* equipment repairs or service maintenance agreements;
* books, periodicals, pamphlets, and memberships;
* advertising;
* registration fees;
* patient transportation;
* training costs, speakers fees and stipends.

INSTRUCTIONS: The OTHER Budget Category Detail Form requires a general description of the service, and the cost. The justification should include an explanation of the purpose of the service and how it is necessary for the completion of the activity. The justification should also include a statement of when services will be utilized if other than the full RFP budget period.

FORM G-8: INDIRECT COST Budget Category Detail Form

Legal Name of Applicant: _____

Complete this form if requesting funds for indirect costs based on Uniform Grants Management Standards. The justification should include an explanation of the purpose of the service and how it is necessary for the completion of the activity.

DESCRIPTION	PURPOSE & JUSTIFICATION
Total Amount Requested for INDIRECT COST:	$

FORM G-8: INDIRECT COST (MATCH) Budget Category Detail Form

Legal Name of Applicant: _____

Complete this form if requesting funds for indirect costs based on Uniform Grants Management Standards. The justification should include an explanation of the purpose of the service and how it is necessary for the completion of the activity.

DESCRIPTION	PURPOSE & JUSTIFICATION
Total Amount Requested for INDIRECT COST:	$

SAMPLE

FORM G-8: INDIRECT COST Budget Category Detail Form Sample

Legal Name of Applicant: Apple County Health Department

Complete this form if requesting funds for indirect costs based on Uniform Grants Management Standards. The justification should include an explanation of the purpose of the service and how it is necessary for the completion of the activity.

DESCRIPTION	PURPOSE & JUSTIFICATION
General administration and maintenance	$2,025
Total Amount Requested for INDIRECT COST:	$2,025

INDIRECT COSTS

DEFINITION: Those costs related to the project that are not included in direct costs. Indirect costs are those costs incurred for a common or joint purpose benefiting more than one cost objective and not readily identified with a particular cost center and which may be paid if allowable under the funding source, e.g., depreciation and use allowances, interest, operation and maintenance expenses (janitorial and utility services, repairs and normal alterations of buildings, furniture, equipment, care of grounds, security), general administration and general expenses (central offices such as director, office of finance, business services, budget and planning, personnel, general counsel, safety and risk management, management information services).

The applicant may negotiate an indirect cost rate with its federal cognizant agency or state coordinating agency. If there is no assigned agency, TDH's Grants Management Division (GMD) may provide guidance on how to have an agency assigned or TDH's GMD may review the applicant's cost allocation plan and negotiate an approved indirect cost rate. The TDH GMD will maintain a listing of agencies and their approved rates. To obtain information about cognizant agencies or negotiating an indirect cost rate, contact the TDH GMD at (512) 458-7111 ext. 2281.

If the applicant does not have an approved indirect cost rate and does not intend to negotiate one, then funds may be budgeted in accordance with Uniform Grant Management Standards (UGMS) which reads as follows:

> "In lieu of determining the actual indirect costs of the service for which a state award is made, a grantee may recover up to 10 percent of the direct salary and wage costs of providing the service (excluding overtime, shift premiums, and fringe benefits) as indirect costs, subject to adequate documentation [of direct salary and wage costs]. Applicants choosing this method of indirect cost recovery are prohibited from seeking recovery using a cost allocation plan, rate or other methods for the same period."

INSTRUCTIONS: Applicant should indicate the indirect cost rate (if applicable) on the BUDGET SUMMARY page and mark the box which contains the appropriate statement regarding the support for the indirect charge. If applicant attaches a copy of the most recently approved indirect cost rate, it should be placed behind the OTHER Budget Category Detail Form. If applicant has marked the box "Uniform Grants Management Standards," then an INDIRECT COST Budget Category Detail Form should be completed. The form requires a description of each type of costs and is necessary a justification. The justification should include an explanation of the purpose of the services and how it is necessary for the completion of the activity.

HISTORICALLY UNDERUTILIZED BUSINESSES (HUBs) Guidelines

- Form C-IGA is required for all applicants.
- If Applicant responds “yes” to both questions on C-IGA, forms C-DGFE and C-SSD must be completed.

FORM H-1: TDH GRANT/CONTRACT APPLICANTS
CLIENT SERVICES HUB SUBCONTRACTING PLAN (C-IGA)

INSTRUCTIONS

HUB Subcontracting Plan (HSP) Policy: In accordance with Texas Government Code, Sections 2161.181-182, Health and Human Service (HHS) agencies shall make a good faith effort to utilize Historically Underutilized Businesses (HUBs) in contracts for construction, services (including professional and consulting services), and commodity procurements. Therefore, HHS contractors shall be required to make a good faith effort to ensure that HUBs receive their respective share of the total value of all subcontract awards each fiscal year. "Subcontract" means a written third party contract between a prime contractor/grantee and another contractor for the performance of all or part of a contract.

The questions below must be completed and returned by applicant with the application.

Applicant (Agency or company) Name (print): _____ Date: _____

TDH Grant/Contract Application Identifier: BCH-School

Yes/No	
☐ ☐	Are you a governmental body (local government, school district, etc.) bound by HUB or MWBE
Yes	If "Yes", complete only the top part of this sheet and return it with your application; no further action is required.
No	If "No", please complete the table below.

Yes/No	
☐ ☐	Is this application for more than $100,000?
☐ ☐	If "Yes" above, do budget categories Equipment, Supplies, Contractual and Other have a combined value of **NOTE: If it is prudent to expect that during the initial contract period the combined subcontracting amount in these budget categories will exceed $50,000, applicant should respond "yes".**
Yes	If "Yes" to both of the above, you MUST comply with the HUB Subcontracting Plan (HSP) Procedures listed below and document your efforts by completing the Determination of Good Faith Effort form (C-DGFE) and the Subcontractor Status Determination form (C-SSD).
No	If "No" to either of the above, you do not have to complete any other HUB forms; however, we encourage you to make efforts to subcontract with qualified HUBs whenever possible in connection with this contract.

HUB Subcontracting Plan (HSP) Procedures

By implementing the following procedures, an applicant shall be presumed to have made a good faith effort to fulfill a HSP.

1. The applicant must notify at least three (3) qualified HUBs of the work that the contractor intends to subcontract. The primary source for finding certified HUBs is the General Services Commission HUB vendor file. These businesses can be located at http://www.gsc.state.tx.us/cmbl/cmblhub.html **(select HUBs on CMBL or HUBs Not on CMBL)**:

- The preferable method of notice shall be in writing;
- The notice must include a quantitative description of the subcontracting work and identify a location or means to review contract specifications;
- The notice must be provided to potential subcontractors prior to submission of the application;
- The applicant must provide potential subcontractors a reasonable period of time to respond to the notice. "Reasonable time" in this context is no less than five working days from receipt of the notice to respond unless circumstances require a different time period, determined by the soliciting agency and documented in the project file.

2. If it is determined that the applicant fails to provide a good faith effort to fulfill these HSP procedures, the applicant's executive director will be notified with a required date for correction of the deficiencies noted.

3. After a contract/grant award, the contractor/grantee shall report to the TDH HUB Coordinator the amount paid to its subcontractors on a quarterly basis using the Quarterly Subcontract Report form (C-QSR) provided in this application.

FORM H-2: TDH GRANT/CONTRACT APPLICANTS
CLIENT SERVICES HUB SUBCONTRACTING PLAN (C-DGFE)

DETERMINATION OF GOOD FAITH EFFORT

Based on applicant's responses to the HUB Subcontracting Plan (HSP) form (C-IGA), applicant may be required to complete and submit this form with the application. The purpose of this form is to document applicant's good faith efforts to develop a HUB subcontracting Plan.

1. Are you certified as a Texas Historically Underutilized Business (HUB)? ☐ Yes ☐ No
2. Do you plan to subcontract all or any portion of the contract? ☐ Yes ☐ No
   If yes, you are required to complete and submit the Subcontractor Status Determination form (C-SSD)

Yes/No	The Texas Department of Health will determine if a good faith effort has been made to develop a HUB Subcontracting Plan based on the responses below	Required Documentation (to be maintained by applicant)
☐ ☐	Did your company divide the contract work into reasonable lots in accordance with standard industry practices?	Statement of compliance methodology
☐ ☐	Did your company send notices containing adequate information about bonding, insurance, plans, specifications, scope of work, and other requirements to three (3) or more qualified HUBs, allowing reasonable time for HUBs to participate effectively?	Phone Logs, Fax Transmittals, etc
☐ ☐	Did your company negotiate in good faith with qualified HUBs, not rejecting qualified HUBs who were the best value responsive bidder?	Selection Process Documentation
☐ ☐	Did your company document reasons for rejection or meet with rejected HUBs to discuss the rejection?	Selection Process Documentation
☐ ☐	Did your company advertise in general circulation, trade association, and minority/women focus media concerning subcontracting opportunities?	Copies of Advertisements
☐ ☐	If you used a source other than the GSC HUB directory, have you identified the subcontractor and the governmental certification source, and assisted the selected minority or women- owned business subcontractor to become certified by GSC?	Subcontractor Status Determination of (C-SSD)

TDH Grant/Contract Application Identifier: ***BCH-School***

Applicant (Agency or Company) Name (print): _____

Authorized Signature and Title: _____ Date: _____

FOR AGENCY USE ONLY:
It is my determination that the applicant - **HAS** _____ - **HAS NOT** _____ - determined good faith according to Texas Government Code, Sections 2161.181-182 in connection with this application. If applicant has not demonstrated good faith, attach explanation.

Reviewed by: _____ Title _____ Date _____

FORM H-3: TDH CLIENT SERVICES HUB SUBCONTRACTING PLAN (C-SSD)

SUBCONTRACTOR STATUS DETERMINATION

Applicant/Prime Contractor's Name: _____

TDH Grant/Contract Identifier: ***BCH-School***

Prime contactor should contact Subcontractor to obtain information as required to complete this form. Include each proposed Subcontractor.

Subcontractor Name	Address	Estimated Dollar Value of Subcontract	Description of Subcontracted Goods and/or Services	If certified as a Minority/Women-Owned Business, enter certification number and certifying entity	If HUB* Qualified, but not Certified enter Qualifying Ethnicity/Gender

*A Historically Underutilized Business (HUB) is defined as a business that is formed for the purpose of making a profit and is otherwise a legally recognized business organization under the laws of the State of Texas. At least 51% of the assets and interest and/or classes of stock and equitable securities must be owned by one or more persons who are United States citizens born or naturalized. The following are recognized by the State of Texas as having been economically disadvantaged because of their identification as members of the **qualifying groups - Asian Pacific Americans (AS), Black Americans (BL), Hispanic Americans (HI), Native Americans (NA), and American Women (WO).** These individuals must demonstrate active participation in the control, operation and management of the daily business affairs of the company that is proportionate to their ownership interest. HUB businesses must have a permanent business office located in Texas where the majority HUB owner(s) makes the decisions, controls the daily operations of the organization, and participates in the business. Owners must be residents of the State of Texas and meet all other certification and compliance requirements. Out-of-state businesses are ineligible for state certification.

FORM H-4: TDH CLIENT SERVICES HUB SUBCONTRACTING PLAN (C-QSR)

QUARTERLY SUCONTRACT REPORT

PRIME CONTRACTOR/GRANTEE INFORMATION: ***Report Quarter:*** _____

Prime Contractor/Grantee Name: _____

Vendor Identification Number: _____ Object Code (agency use): _____

TDH Grant/Contract Identifier: BCH-School Total Contract Amount: _____

Address: _____ Telephone #: _____ Fax#: _____

SUBCONTRACTOR INFORMATION:

Subcontractor Name	Vendor Identification Number	If HUB Qualified But Not Certified, Enter Qualifying Ethnicity/Gender	Description of Services/ Materials Provide	Contact Person & Telephone Number	Amount Paid This Date	Amount Paid To Date
					$	$
					$	$
					$	$
					$	$
					$	$
				Total Reported:	$ 0	$ 0

Please check here ☐ if NO subcontractors have been utilized during this quarter.

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

Signature /Authorized Representative: _____ **Date:** _____

Send This To: Texas Department of Health
HUB Coordinator
1100 West 49th Street
Austin, Texas 78756-3199

Quarter	Months Included	Deadline
First	*September, October, November*	*December 5th*
Second	*December, January, February*	*March 5th*
Third	*March, April, May*	*June 5th*
Fourth	*June, July, August*	*September 5th*

FORM I : NONPROFIT BOARD OF DIRECTORS AND EXECUTIVE DIRECTOR ASSURANCES FORM

If the applicant is a nonprofit organization, this form must be completed (state or other governmental agencies are not required to complete this form). The purpose of the form is to inform nonprofit board members and officers of the responsibilities and administrative oversight requirements of nonprofit applicants intending to or contracting with TDH.

(Name & Address Of Organization)

The persons signing on behalf of the above named organization certify that they are duly authorized to sign this Assurances form on behalf of the organization. The undersigned acknowledge and affirm:

A. That an annual budget has been approved for each contract with TDH.

B. The Board of Directors convenes on a regularly scheduled basis (no less than quarterly) to discuss the operations of the organization.

C. Actual revenue and expenses are compared with the approved budget, variances are noted, and corrective action taken as needed (with Board approval).

D. Timely and accurate financial statements are presented by the designated financial officer on a regular basis to the board.

E. That the Board of Directors will ensure that any required financial reports and forms, whether federal or state, are filed on a current and timely basis.

F. Adequate internal controls are in place to ensure fiscal integrity and accountability and to safeguard assets.

G. The Treasurer of the Board has been fully informed of his or her responsibilities as Treasurer.

H. The Board has Audit and/or Finance Committees that convene regularly and communicate effectively with the Board Treasurer and other Board members in understanding and responding to financial developments.

I. The organization observes Generally Accepted Accounting Principles when preparing financial statements and fund accounting practices are observed to ensure integrity among specific contracts or grants.

J. If a contract is executed with the Texas Department of Health, this form will be discussed in detail at the next official Board meeting and that notes of the discussion and a signed copy of this form will be included in the minutes of the meeting. A copy of the minutes will be forwarded to the Texas Department of Health's Grants Management Division, no later than 45 days after the meeting in which the form was discussed.

K. If a contract is executed with the Texas Department of Health and the nonprofit organization has not received any funding from TDH for the past 24 months, the Legal and Fiscal Responsibilities for Nonprofit Board of Directors Video and Guide will be viewed and a signed "tear-out" sheet will be completed and filed by each board member with the nonprofit organization no later than 45 days after contract execution. Newly appointed/elected board members will comply with these requirements no more than 45 days after taking office. All tear-out sheets will be available for inspection by TDH staff.

***Chairman of the Board Signature/Date**

*President or Executive Director Signature/Date

*If the signed original of this form has been provided to the Texas Department of Health during the calendar year and the officers signing the document have not changed, a copy of the signed form will be accepted.

FORM J: Proposed Services Form

Location of Proposed School-Based Health Center

City: _____ **County:** _____ **Public Health Region:** _____

Name of School District(s) Served: _____

School campus(es) where school-based health services will be provided (either on-site or via mobile clinic unit):

	Name of School/Campus (and district if more than one served)	Enrollment
1		
2		
3		
4		
5		

Other campuses to be served by school-based health center project:

1		
2		
3		

Total enrollment of campuses to be served by school-based health center (*target population*): _____

Estimated number of unduplicated clients (students) to be served in the school-based health center during State fiscal year 2003 (September 1, 2002 through August 31, 2003): _____

Percentage of target population to be served: _____

Estimated number of unduplicated clients (other than students) to be served in the school-based health center during State fiscal year 2003 (September 1, 2002 through August 31, 2003): _____

TOTAL estimated number of clients to be served: _____

Who will be served? (check all that apply):

_____ **Students** _____ **Siblings** _____ **Parents** _____ **Children of Students** _____ **Other**

Do you currently have a Medicaid provider number? _____ **Yes** _____ **No** **Number:** _____

Do you currently have a Texas Health Steps provider number? _____ **Yes** _____ **No** **Number:** _____

Estimated number and percent of students in *target population* who are Medicaid eligible: **#:** _____ **%:** _____

Number and percent of students in target population participating in free/reduced price school lunch program: **#:** _____ **%:** _____

Estimated number of students in target population who are in ESL and/or bilingual programs: _____

Estimated number of students in target population who do not have a medical home: _____

Estimated number of students in target population who do not have any form of health insurance at all (including Medicaid, CHIP, etc.): _____

Legal Name of Applicant: _____

FORM J: Proposed Services Form - continued

SERVICES TO BE PROVIDED: (please check all that apply to your proposed school-based health center)

On-Site	Referral*	(*If services will be provided by referral, please identify the referral agency under "LINKAGES")
		Maintenance of a health record and a health plan for participating students
		Case management of the participating student's health activities, including referral and case management of chronic illness and emergencies
		Physical examinations
		Preventive comprehensive well-child assessments including Texas Health Steps (EPSDT) screening, (nutritional, developmental, and mental heatlh assessments and anticipatory guidance)
		Dental screening and referral for service
		Immunizations for all children in the school's attendance zone
		Diagnosis and treatment of minor illnesses, communicable diseases and minor injuries
		Basic laboratory services (or arrangement for convenient access to services)
		Dispensing of medications for services
		Education and counseling program (in coordination with classroom instruction) addressing nutrition, fitness and the prevention of substance abuse, disease, and injury
		Mental health and psychosocial counseling
		Provision of pregnancy testing
		Provision of prenatal care
		WIC services
		Prenatal care and post-partum care
		Well-child care for children of students
		Substance abuse treatment

LINKAGES: (List hospitals, clinincs, and/or private practice physicians with whom you have written agreements to provide after-hours and weekend primary care services and specialty services to your targeted population)

_____

_____

_____

_____

_____

HOURS: (List hours that primary care services will be available on-site in the school-based health center)

Monday:	_____	**Tuesday:**	_____
Wednesday:	_____	**Thursday:**	_____
Friday:	_____	**Saturday:**	_____

Sunday:

APPENDIX A
TDH ASSURANCES AND CERTIFICATIONS

Note: Some of these Assurances and Certifications may not be applicable to your project. If you have questions, contact the awarding program within TDH.

As the duly authorized representative of the applicant, my signature on the FACE PAGE Form certifies that the applicant:

1. Has the legal authority to apply for state/federal assistance, and the institutional, managerial and financial capability and systems (including funds sufficient to pay the non-state/federal share of project costs) to ensure proper planning, management and completion of the project described in this application;
2. Will honor for 90 days after the application due date the technical and business terms contained in the application;
3. Will initiate the work after receipt of a fully executed contract and will complete it within the contract period;
4. Will remain current in its payment of franchise tax or is exempt from payment of franchise taxes, if applicable;
5. Affirms that it has not given, nor intends to give, at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant or any employee or representative of same, in connection with this procurement;
6. Will not require a client to provide or pay for the services of a translator or interpreter;
7. Will identify and document on client records the primary language/dialect of a client who has limited English proficiency and the need for translation or interpretation services;
8. Will make every effort to avoid use of any persons under the age of 18 or any family member or friend of a client as an interpreter for essential communications with clients who have limited English proficiency. However, a family member or friend may be used as an interpreter if this is requested by the client and the use of such a person would not compromise the effectiveness of services or violates the client's confidentiality, and the client is advised that a free interpreter is available;
9. Will comply with all applicable requirements of all other state/federal laws, executive orders, regulations, and policies governing this program.
10. Defined as the primary participant in accordance with 45 CFR Part 76, and his/her principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department or agency;
(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (federal, state, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (federal, state, or local) terminated for cause or default.

Should the applicant not be able to provide this certification (by signing the FACE PAGE Form), an explanation should be placed after this form in the application response.

The applicant agrees by submitting this proposal that he/she will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion-Lower Tier Covered Transaction" (Appendix B to 45 CFR Part 76) in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions.

11. Understands that Title 31, USC §1352, entitled "Limitation on use of appropriated funds to influence certain federal contracting and financial transactions," generally prohibits recipients of federal grants and cooperative agreements from using federal (appropriated) funds for lobbying the executive or legislative branches of the federal government in connection with a **SPECIFIC** grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a federal grant or cooperative agreement must disclose lobbying undertaken with non-federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).
    (a) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.
    (b) If any funds other than federally-appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or

employee of any agent, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," (SF-LLL) in accordance with its instructions. SF-LLL and continuation sheet are included at the end of this application form.

(c) The language of this certification shall be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by USC §1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

12. Affirms that the statements herein are true, accurate, and complete (to the best of his or her knowledge and belief), and agrees to comply with the TDH terms and conditions if an award is issued as a result of this application. Willful provision of false information is a criminal offense (Title 18, USC §1001). Any person making any false, fictitious, or fraudulent statement may, in addition to other remedies available to the Government, be subject to civil penalties under the Program Fraud Civil Remedies Act of 1986 (45 CFR Part 79).